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ABSTRACT

A cross-cultural study was conducted on California's Multipurpose Senior Services Project, a case management project designed to improve community-based care for the elderly. The coping style differences between Hispanic and Anglo clients and the treatment style differences between Hispanic and Anglo workers were examined through structured interviews with 15 clients and 5 workers at a predominantly Hispanic site, and with 15 clients and 5 workers at a predominantly Anglo site. Differences were found between Hispanic and Anglo sites in terms of sociodemographic characteristics of the clients, client coping styles, and worker treatment styles. The data related to client coping style showed that the Anglos were somewhat more agency-oriented than the Hispanics but the report showed no appreciable ethnic difference in level of informal support. Both groups expressed dissatisfaction with the quality of familial supports. The data related to worker treatment style suggested that certain features of a case management project made it more effective and culturally relevant to the Hispanic elderly. Those features included the emphasis on paraprofessional involvement, the advocacy role of the agency, the enhancement of the client's informal support system, involvement in atypical functions, and intense case involvement. (NRB)

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The Administration of Case Coordination Programs Serving the Hispanic and Anglo Elderly

by

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INTRODUCTION

Case coordination projects have sprung up throughout the country to address service delivery obstacles to the nation's elderly. Yet very few of these efforts are developing case management models that are attuned to the characteristics of the Hispanic elderly.[1] Some factors which have been found to affect service utilization by elderly Hispanics include language, education, access, and health status. (Szapocznik et al., 1979).

A crosscultural study was conducted on the Multipurpose Senior Services Project (or MSSP), a major case management effort being conducted in California. The purpose of the study was twofold: first, to examine the coping style differences between Hispanic and Anglo clients, and second, to examine the treatment style differences between Hispanic and Anglo workers. Worker treatment style is defined as those specific activities and functions which workers perform to meet the needs of their clients. Client coping style is defined as the extent to which seniors rely on formal agency services versus informal networks (i.e., familial supports) to meet their needs.

This paper is presented in the following manner. First, an overview of the literature related to the help-seeking patterns of the Hispanic elderly and to the importance of case management to this population is given. This is followed by a brief description of the MSSP in California and of the two communities of the MSSP sites which were studied. Next, the study's research methodology is discussed. Then, the study's findings are reported in terms of: a) the sociodemographic characteristics of the Hispanic and Anglo elderly samples, b) the coping style patterns of the Hispanic and Anglo cients, and c) the treatment style patterns of the Hispanic and Anglo workers.

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[1] Note: The term "Hispanic" refers to all persons of Latin American descent. The term "elderly" refers to those persons age 65 years and over.

LITERATURE

The literature clearly documents that elderly Hispanics are a high risk group because of their serious health and social problems (Newquist et al., 1979). Their unique sociocultural characteristics raise questions about how best to serve them in a case management program. Consequently, the connecting service movement has great potential in minority communities, yet much needs to be learned about the application of case management models to diverse populations.

There are specific areas in the literature regarding Hispanic health behavior which distinguish service provision to this group. These are related to: 1) the help-seeking patterns of the Hispanic elderly and 2) the multiple roles and staffing needs of programs serving the Hispanic elderly.

The literature regarding the help-seeking patterns of Hispanics is vast and many-sided. However, the literature clearly shows that the informal support systems of the elderly Hispanic are evolving and changing. Traditional familial support systems are being replaced by what Litwak (1965) termed as "modified extended families." The introduction of the "servidora" (or caretaker) concept by Valle and Mendoza (1978) reveals that nonfamilial networks are also important sources of social support. Newton's review of the literature on this topic in 1980 led to the conclusion that the Hispanic elderly utilize both informal networks and formal agency services. Their choice of type of support depends on the area of need and the particular circumstances of the elderly person. Defining how this mixed coping style is manifested among frail elderly in a case management program is the challenge that faces researchers and service providers alike.

The literature regarding the provision of services to the Hispanic elderly suggests that workers must perform multiple roles which require reliance on both professionals and paraprofessionals. Downing (1979) has identified three problem areas in service provision which require case coordination workers to perform multiple roles. These services use barriers are the following.

1) The elderly are unaware of existing service and do not know how to use them.

2) The service systems for the elderly are oftentimes characterized by gaps in service, poor quality, and inappropriateness.

3) The elderly, particularly those who are socially isolated, are likely to harbor negative attitudes and resistance regarding the use of formal services because of past unsatisfactory experiences with the system and fears of dependency.

These barriers are compounded among elderly Hispanics largely because of their linguistic/cultural differences and the uneven distribution of services in diverse communities.

Downing (1980) summarized the desired characteristics of minority elderly case coordination programs as reliance on the following factors:

1) minority staff who are familiar with the language and culture of the target population;

2) paraprofessionals as outreach workers;

3) special treatment methods, focusing on expertise in the areas of advocacy, counseling, and coordination; and

4) an informal client pathway.

Defining the specific treatment style characteristics of a "culturally relevant" case management model is important to improve the delivery of services to the Hispanic elderly.

MSSP/TARGET COMMUNITIES DESCRIPTION

Before describing the MSSP in California and the two particular MSSP sites which were studied, case management will be described. The purpose of case management is to access the multi-problem client to the full range of services which he/she requires. Although case management approaches vary widely, there are three generally recgonized steps in case management. They are as follows:

1) The client's needs (health and psychosocial) are assessed.

2) A care plan is developed to address those needs.

3) The care plan is implemented and ongoing monitoring of service provision and client status takes place.

The Multi-Purpose Senior Service Project (MSSP) was authorized by the California Legislature in 1977 in response to the Legislature's increasing interest in improving the State's system of community-based care for the elderly. During its "project" phase from 1980 to 1983, the MSSP served as a Statewide research and demonstration project, administered by the California State Health and Welfare Agency with eight local demonstration sites. The major objectives of the MSSP are to:

(1) test methods of managing access to social and health services for "frail" older persons so that they can remain living independently, and

(2) provide for efficient and effective use of public funds in the delivery of those services.

In 1983, the MSSP was converted into a "program," targeting "threshold" clients or seniors at immediate risk of institutionalization.

The unique feature of the MSSP is that it allows for purchase of client sevices if these services are not available through an existing program or through the client's informal network. The purchase of services is made possible through Medi-Caid (or Medi-Cal in California) waivers granted by HCFA, the Health Care Financing Administration. These waivers allow an expansion of traditional Medi-Caid services to include case management and a broad range of in-home and community-based services. Case management programs like the MSSP are hightly significantly in minority communities because of the potential they create for improving existing services and developing new ones.

The study was conducted in 1980 during the first year of operation of the MSSP. The subjects for the study were selected from two MSSP sites, one predominately Hispanic and the other predominately Anglo. The Hispanic MSSP site is located in East Los Angeles (ELA) and the Anglo MSSP site is located in Long Beach (LB). Aside from differences in ethnic compostion, the two communities differ on other characteristics as well. The ELA community is characterized by high levels of poverty and disease, and the elderly constitute 8% of the population of 500,000. In contrast, the LB community, an oceanfront city, exhibits the affluence of a middle-class retirement community, and the elderly constitute 21% of the population of 380,000. Because of the large senior citizen community in LB, a comprehensive service delivery structure has been developed for this population. In contrast, services for seniors in ELA have been fragmented and oftentimes unavailable.

RESEARCH METHODOLOGY

In terms of research design, a case study approach was utilized to explore and describe the crosscultural differences in serving a Hispanic versus Anglo population in the MSSP. In-depth structured interviews were conducted with the clients and workers of the ELA site and of the LB site. A total of 30 clients, 15 Hispanics and 15 Anglos, were interviewed. A total of 10 workers were interviewed, 5 in each site. The five workers in each site included two case managers, two case aides, and one nurse — or two case management teams. The objective was to interview each member of the case management team which was involved with each client in the sample. So for each of the 30 clients interviewed, three workers were interviewed regarding that particular client case -- to get the perspective of each -- the case manager, the case aide, and the nurse. Consequently, 90 case interviews were completed with the workers. The primary screening criteria for selecting the clients was that all the team members had been sufficiently involved with the client that that person would be able to answer questions about the workers. All the workers, except the nurse, were Hispanic in the ELA site. All the workers, except the case aides, were Anglo in the LB site.

FINDINGS

The findings generally show that there were sharp differences between the Hispanic sample and the Anglo sample. Because of the small sample size and the use of nonrandom selection methods, these findings cannot be generalized to each of the agencies involved or to other seniors who have these characteristics. However, the sociodemographic data clearly supports national statistics regarding the Hispanic elderly. The coping style of the Hispanic and Anglo client samples differed in terms of formal service use but not in terms of informal service use. The treatment style of the ELA workers was vastly different from the treatment style of the LB workers.

a) Sociodemographic Characteristics

Overall, the client sample was predominately female (75%), and fairly even proportions of the "young-old" and "old-old" were interviewed in both agencies. According to MSSP policy, they were all Medi-Caid eligible and had met at least one of the criteria for being considered frail and at risk of institutionalization, such as a recent hospitalization, a stay in a SNF, or being 75 years of age or older.

Sociodemographic data on the client sample showed that there were sharp cross-cultural differences. The ethnic distribution of client functional level as determined by client scores on the IADL (Table 1) approached statistical significance (chi square = 3.33, $p \sim .07$). Among the Anglo clients in LB, two-thirds were high functioning. In ELA the opposite was found. Two-thirds of the Hispanics were medium or low functioning.

There were also ethnic differences in terms of living arrangements. Similar proportions of the Hispanics and Anglos (40% and 53% respectively) lived alone. However, the remaining 60% of Hispanics lived with a family member (47%) or a relative/friend (13%). In contrast, the remaining half of Anglos lived primarily in institutional settings (33%). It is interesting that the Hispanics relied heavily on social supports in their living arrangements, instead of institutional care, despite their lower functional level.

There were also highly significant differences in the educational level of the clients. ($F=17.64$, $p < .01$). The Anglos averaged ten years of education; the Hispanics averaged less than half that number - or four years of education. Forty percent of the Hispanics had no formal education at all.

By virtue of the ethnicity of the clients, there were also sharp differences in place of birth and language. Two-thirds of the Hispanics were born in Mexico; the rest were born in the Southwest, mainly California. The Anglos were primarily U.S. born (87%) in States other than California (60%). In terms of language, 60% of the Hispanic elderly viewed Spanish as their primary language; the remaining 40% viewed themselves as bilingual.

In terms of residency, the Hispanic elderly had a longer length of current city residency than the Anglo elderly. Most of the Hispanics (93%) had lived in Los Angeles for more than 20 years in comparison to 60% of their Anglo counterparts. In addition, the vast majority of the LB respondents (87%) had less than 10 years in their home compared to 53% of the ELA respondents.

b) Client Coping Style Findings

The data related to client coping style showed that the Anglos were somewhat more agency-oriented than the Hispanics with no appreciable ethnic difference in level of informal support. Analysis of variance techniques were used to determine if there were crosscultural differences in the number of service categories, service providers, and caretakers which were utilized by clients since entry into the MSSP. Data suggestive of significance showed that the Anglo clients used more MSSP service categories ($F=3.59$, $p \sim .07$) and, service providers within service categories ($F=3.41$, $p \sim .08$), than the Hispanic clients. Table 2 shows that in terms of service categories, Hispanics used an average of eight services; and Anglos used an average of 10 services. In terms of service providers, Hispanics used an average of nine providers; and Anglos used an average of 11. Compared to Anglos, Hispanics were not using specialized communication services and

adult social day care. Hispanics used other services less than Anglos: friendly visitor, shopping assistance, and specialty medical services (i.e., optometrist, podiatrist). Some of these services were not in place at the time of date collection; however, the question remains whether these services would have been used even if they were available.

The data on client coping style also showed that the Hispanic elderly did not rely on informal networks to a significantly greater degree than the Anglo clients ($F=.82$, $p > .10$). However, when they did rely on informal support, the types of caretakers between the two groups were very different. Table 2 shows that both Hispanics and Anglos had an average of two caretakers. Similar proportions (two-thirds of the Hispanics and one-half of the Anglos) said that they had a caretaker. The slightly higher prevalence of caretakers in ELA was due to a higher reporting of homemakers as caretakers in ELA (40% in ELA and 20% in LB). In addition, the caretakers in the homemaker catergory were very different in the two agencies. In LB, the homemaker was usually a family member. In ELA, the homemaker was usually a new friend of the client who had became a strong support system. It is important to note that were it not for the homemakers in the ELA sample, two-thirds of the Hispanics would not have had a caretaker. It is also important to note that both clients and workers in the sample, regardless of ethnicity, tended to rate the quality of available informal/familial support very low. It may be that the common factor shared by all the clients -- high risk -- is closely related to a loss or absence of social support which leads to a primary reliance on formal sources of assistance.

c) Worker Treatment Style Findings

In terms of worker treatment style findings, there were significant interagency differences. Client data showed heavy reliance on the paraprofessional staff in ELA versus the professional staff in LB. Worker data showed that, in comparison to LB, ELA exhibited:

1) a higher degree of worker involvement with clients,

2) a more versatile team approach,

3) a different pattern of worker role progession and emphases, and

4) a greater range of atypical functions.

Client and worker data show that a flexible resource system is more appropriate for the ELA clients than a traditional case management approach. On one item (Table 3) the clients were asked which type of provider they turned to most for assistance. Ninety percent of the Anglo clients turned to the case manager. In contrast, the majority of the Hispanics (60%) turned to other staff, primarily the case aide, but also the nurse and the homemaker. This finding was highly significant (chi square = 8.95, $p < .01$).

On another set of items (Table 4) the workers were asked to rank the order in which they and their fellow team members were involved in the monitoring of service provision. The LB worker reports generally reflected the traditional ranking of workers in case management (first the case manager, second the case aide and third the nurse). Unlike LB, the ELA data showed that all three job categories were equally represented in the number one slot, and both the case aide and the nurse shared equal proportions of time in the second and third rankings. These findings were also highly significant. (On worker ranked number one, chi square = 26.13, $p < .01$; on worker ranked number two, chi square = 19.01, $p < .01$; on worker ranked number three, chi square = 6.44, $p \sim .02$).

The frequency with which workers were involved in standard and nontraditional case management functions was examined through the use of Likert-type scales (Table 5). Standard case management activities (or the worker centered items) were defined as those involving coordination of client services and counseling regarding service use. The ELA workers reported being involved in these functions with their clients significantly more than the LB workers ($F=12.05$, $p < .01$). ELA on an average was involved in these activities "often" (three to five times) and LB "seldom" (one or two times). Nontraditional

case management activities (or the client-centered items) were defined as those involving social support advocacy, agency advocacy, and supportive services in daily living. Both agencies engaged in these activities "seldom" although ELA's average was higher than LB ($F=.92$, $p > .10$). Generally speaking, these data show that the ELA sample was more actively involved with its clients than the LB sample.

Interagency differences in worker role emphases were also evident. The workers were asked to rank by order of importance the roles which were performed by the workers in each client case (Table 6). The roles which were prioritized included: coordinating, counseling, and advocacy. LB workers consistently ranked the coordination role higher than the ELA workers. The ELA workers ranked the advocacy role significantly higher than the LB workers. (On role ranked first, chi square = 2.26, $p > .10$; on role ranked second, chi square = 1.98, $p > .10$; on role ranked third, chi square = 9.13, $p < .01$). In addition, ELA workers reported being much more likely to undergo changes in role emphases than the LB workers (80% versus 5%). The bulk of ELA role change was towards less advocacy and more coordination. In LB, the opposite was found.

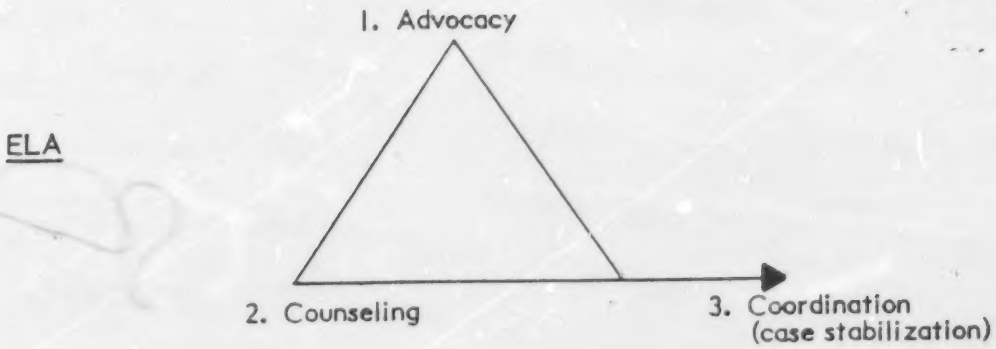
Therefore, the general patterns of role progression were very different between the two agencies. As Figure 1 ilustrates, the LB workers maintained a coordination focus unless the need for advocacy arose which was not often. ELA workers were much more likely to focus on advocacy and counseling first, then turn to coordination once the case had stabilized. The trends in both agencies may reflect the presence of a much smoother service delivery process in LB than in ELA so that advocacy and frequent client involvement is not much needed in LB and standard coordination becomes an appropriate way of managing cases in LB.

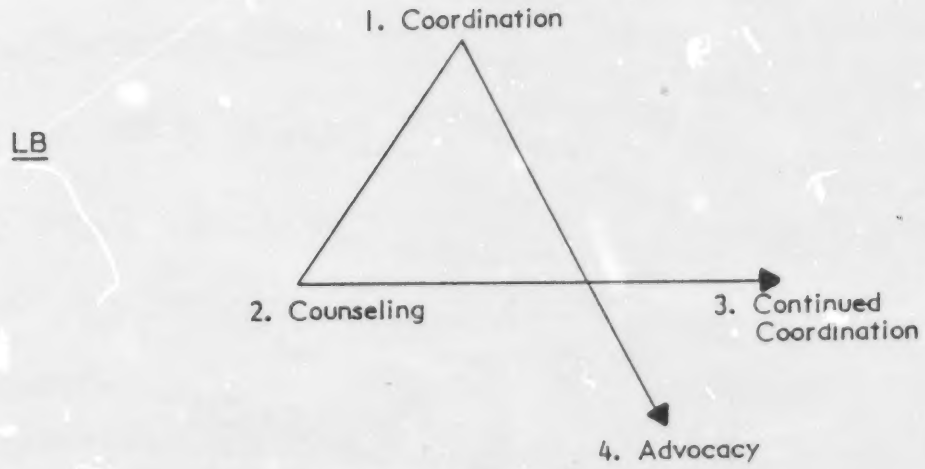
In addition to patterns of role progression, the workers were also asked if they performed functions that they did not typically perform with other clients. Both agencies said that they did not perform atypical activities over half of the time (60%). But in the

FIGURE 1

A COMPARISON OF WORKER ROLE PROGRESSION

BETWEEN ELA AND LB





remaining time, ELA workers reported a greater range of atypical activities than LB. LB workers defined their atypical activities as frequent client contact (24%) and advocacy (11%). ELA workers defined their atypical activities as: 1) advocacy (13%), 2) counseling and assistance to family and homemakers (18%), 3) special consultations with community providers (7%), and 4) frequent client contact (4%).

In addition, ELA workers were more likely to have made contact with the client's social support system than the LB workers. Staff made contact with the client's supports over 90% of the time in ELA versus 60% of the time in LB. Because of the amount of advocacy required (with agencies and social supports) for Hispanic seniors, the ELA staff found the service delivery phase of case management significantly more difficult than the LB staff (chi square = 3.62, $p \sim .06$).

SUMMARY

In summary, the differences between ELA and LB in terms of client socio-demographic characteristics, client coping style, and worker treatment style are striking. The differences in agency operation can be attributed in part to the higher risk status of the Hispanic elderly which has been documented here and in the literature. But it appears that an even more critical factor is related to the availability of a comprehensive and adequate supply of quality services. The case management program in ELA at the time of the study was functioning in a service system characterized by gaps in resources which MSSP set out to ameliorate. In contrast, the LB setting has had a long-standing, well developed system for serving seniors in the community. Therefore, the worker focus in each agency was appropriate to the scope of resources which was available in each particular community.

The data related to worker treatment style show that certain features of a case management program make it more effective and culturally relevant to the Hispanic elderly. These include:

1) team sharing of roles, with a heavy emphasis on paraprofessional involvement;

2) role flexibility, with a heavy emphasis on agency advocacy;

3) enhancement of the client's informal support system, particularly in relation to homemakers;

4) involvement in atypical functions (i.e., escort); and

5) intense case involvement, calling for constant monitoring of the status of cases.

The coping style data show that both the Hispanics and the Anglos relied on a combination of formal and informal support systems. LB clients were slightly heavier agency users than the ELA clients. ELA clients appeared to have more caretakers largely because of the special role of homemakers. Both ELA and LB expressed general dissatisfaction with the quality of familial supports. These data on informal supports is at odds with the generally-held notion that the elderly, particularly its minority members, rely significantly upon informal assistance. Clearly, concrete data that evaluates the quality of social support is needed to substantiate such claims.

In conclusion, this study represents an exploratory attempt to identify the major distinctions in administering a case management program with the Hispanic elderly. Case management presents an ideal opportunity to address the severe problems facing elderly Hispanics and their communities. The results of this study would lend support towards: (1) greater recognition of the nontraditional aspects of case management, and (2) more specialized training for present and prospective workers in minority case management programs, and (3) more funding of comprehensive, community-based programs in minority communities.

RECOMENDATIONS

The following recommendations are made based on the results of this study. First, it is important that government mandate support for features of case management which are nontraditional in nature, because they constitute a significant core of worker activity in minority-oriented programs. These nontraditional activities include agency and social support advocacy, assistance in daily living, and relationship-building and team-building functions. An avenue for achieving this objective can be found in state and local government units. It is important that these entities incorporate in their aging policy, standards regarding service delivery which encourage senior providers to adapt to the characteristics and needs of the population being served. This is particularly important in highly diverse population areas such as California where the institution of rigid standards of care would be deleterious to its long-term care reform efforts.

Second, it is important that government, academic institutions, and other organizations increase their development of specialized training programs related to the minority elderly, both for new workers in the gerontological field and for workers already out in the community. Possible vehicles for addressing this concern include federal funding sources of geriatric, social work, and nursing training programs which can make more allocations for the preparation and continuing education of workers in the field of minority gerontology. Academic institutions can incorporate more curriculum and internship experiences of relevance to the minority elderly in their existing social work, nursing and gerontology programs. Organizations which are responsible for setting licensing and certification standards for nurses, social workers, and gerontologists can include specific criteria which require the applicant to demonstrate ability to work with special populations if work in predominately minority areas is indicated.

Third, it is important that government enlarge its role i.. shifting programs from a focus on brokerage models of delivery, which have obvious shortcomings in minority communities, to more comprehensive service delivery programs for the elderly. Movement towards this direction can be facilitated by federal agencies -- particularly the Social Security Administration, the Health Care Financing Administration, and the Administration on Aging. By following closely the results of their research and demonstration projects (such as the Multipurpose Senior Service Project) and considering their replication in other minority communities, these agencies can contribute to the revision of national policy so that ultimately community-based programs for the elderly will receive ongoing financial support.

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TABLES

TABLE 1

ETHNIC DISTRIBUTION OF CLIENT FUNCTIONAL LEVEL

Client Ethnicity	FUNCTIONAL LEVEL High	Medium/Low
Hispanic	5 (33.3)	10 (66.7)
Anglo	10 (66.7)	5 (33.3)
Total N	15	15

CHI SQUARE = 3.333 WITH 1 DEGREE OF FREEDOM
$p \sim .07$

TABLE 2

RELATIONSHIP BETWEEN CLIENT ETHNICITY
AND THE EXTENT OF FORMAL/INFORMAL SERVICE USE

CLIENT ETHNICITY	EXTENT OF FORMAL/INFORMAL SERVICE USE		
	Mean Number of Service Categories	Mean Number of Service Providers	Mean Number of Caretakers
Hispanic	8.33	09.40	1.93
Anglo	9.80	11.00	1.60
F Value	3.59	3.41	0.82
Degrees of Freedom	1/28	1/28	1/28
P Value	∿.07	∿.08	> .10

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TABLE 3

PREFERENCE FOR CASE MANAGER VERSUS OTHER STAFF BY CLIENT ETHNICITY

PREFERENCE FOR PROVIDER TYPE (JOB CATEGORY)	CLIENT ETHNICITY	
	HISPANIC	ANGLO
Case Manager	6 (40.0)	13 (92.9)
Other Staff	9 (60.0)	1 (7.1)
Total N	15	14*

CHI SQUARE = 8.955 WITH 1 DEGREE OF FREEDOM
$p < .01$

*One LB client did not know who she/he turned to most.

TABLE 4

Responses by Agency Setting to the Question, "Please rate by order of importance the degree to which you have relied on each staff person -- case manager, case aide, and nurse -- during the service delivery phase with this client."

RANKING OF STAFF INVOLVEMENT DURING SERVICE DELIVERY

	STAFF RANKED NUMBER ONE			STAFF RANKED NUMBER TWO			STAFF RANKED NUMBER THREE		
AGENCY SETTING	Case Manager	Case Aide	Nurse	Case Manager	Case Aide	Nurse	Case Manager	Case Aide	Nurse
ELA (% of time)	16 (35.6)	14 (31.1)	15 (33.3)	21 (46.7)	13 (28.9)	11 (24.4)	6 (13.3)	22 (48.9)	17 (37.8)
LB (% of time)	39 (86.7)	5 (11.1)	1 (2.2)	3 (6.7)	27 (60.0)	15 (33.3)	3 (6.7)	13 (28.9)	29 (64.4)
TOTAL N (Client Cases)	55 (61.1)	19 (21.1)	16 (17.8)	24 (26.7)	40 (44.4)	26 (28.9)	9 (10.0)	35 (38.9)	46 (51.1)

CHI SQUARE = 26.131 WITH 2 DEGREES OF FREEDOM $p = .0001$

CHI SQUARE = 19.015 WITH 2 DEGREES FREEDOM $p = .0001$

CHI SQUARE = 6.445 WITH 2 DEGREES OF FREEDOM $p \sim .02$

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TABLE 5

RELATIONSHIP BETWEEN AGENCY SETTING AND FREQUENCY OF WORKER INVOLVEMENT IN CASE MANAGEMENT

AGENCY SETTING	FREQUENCY OF WORKER INVOLVEMENT: MEAN-WORKER SCALE ON WORKER-CENTERED ITEMS	FREQUENCY OF WORKER INVOLVEMENT: MEAN-WORKER SCALE ON CLIENT-CENTERED ITEMS
ELA	2.123	1.037
LB	1.647	0.913

ON WORKER-CENTERED ITEMS:

F VALUE = 12.05 WITH 1/88 DEGREES OF FREEDOM
$p = .0008$

ON CLIENT-CENTERED ITEMS:

F VALUE = 0.92 WITH 1/88 DEGREES OF FREEDOM
$p > .10$

TABLE 6

Responses by Agency Setting to the Question, "Please rate by order of importance the major roles that you perform as a worker for this client: coordinating, counseling, and advocacy."

AGENCY SETTING	RANKING OF WORKER ROLES								
	ROLE RANKED NUMBER ONE			ROLE RANKED NUMBER TWO			ROLE RANKED NUMBER THREE		
	Coordinate	Counsel	Advocate	Coordinate	Counsel	Advocate	Coordinate	Counsel	Advocate
ELA (% of time)	25 (55.6)	11 (24.4)	9 (20.0)	14 (31.1)	15 (33.33)	16 (35.6)	6 (13.3)	19 (42.2)	20 (44.5)
LB (% of time)	29 (64.4)	12 (26.7)	4 (8.9)	16 (35.6)	19 (42.2)	10 (22.2)	0 (0.0)	14 (31.1)	31 (68.9)
TOTAL N (Client Cases)	54 (60.0)	23 (25.6)	13 (14.4)	30 (33.3)	34 (37.8)	26 (28.9)	6 (6.7)	33 (36.7)	51 (56.6)

CHI SQUARE = 2.263 WITH 2 DEGREES OF FREEDOM $p > .10$

CHI SQUARE = 1.989 WITH 2 DEGREES OF FREEDOM $p > .10$

CHI SQUARE = 9.130 WITH 2 DEGREES OF FREEDOM $p < .01$

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